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Hampson, Margaret; Watt, Bruce D.; Hicks, Richard E.

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Perspectives on Recovery in Psychosis

Hampson, Margaret Elizabeth¹
Watt, Bruce¹
Hicks, Richard¹

¹ School of Psychology, Bond University, Robina, Gold Coast, Australia



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KEYWORDS

Psychosis, Recovery

Abstract

This paper explores the concept of recovery in relation to people living with psychosis. Previous studies have examined recovery from the perspectives of clinicians and people living with psychosis. This article examines perceptions of recovery among multiple stakeholder groups.

Research Design and Method: The study used data from a large Australian qualitative study which investigated employment barriers and support needs of people living with psychosis. The sample comprised 137 participants drawn from six key stakeholder groups: people living with psychosis; care-givers; health professionals; employers; employment consultants; and community members. Data gathered during 14 focus groups and 31 individual interviews were imported into NVivo 10 and analyzed using thematic analysis.

Results: Five themes were identified in relation to the perceived meaning of recovery in psychosis: symptomatic relief; a contented life; a meaningful life; a contributing life and functional improvement.

Conclusions: The findings highlight the diverse perceptions that exist among stakeholders regarding what constitutes recovery in psychosis.

Introduction

The concept of recovery in relation to severe and persisting mental health conditions is a complex one¹. The current emphasis on recovery-oriented services in mental health belies the reality that recovery remains an elusive construct with varied proposed definitions, and differing approaches to measurement². A thorough grasp of the concept

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Corresponding Author: Margaret Elizabeth Hampson, School of Psychology, Bond University, University Drive, Robina, Gold Coast, Australia. Email: mhampson@aapt.net.au

of recovery is necessary for progress in theory, research, clinical practice, and evaluation of the cost-effectiveness of recovery-oriented services. Having a clearer understanding of what constitutes recovery can assist researchers and clinicians to investigate related areas such as the processes involved in recovery and identifying key mechanisms to facilitate recovery. Indeed, one study identified broadening cultural understandings of recovery as a key scientific challenge for the future³. The following literature review will explore historical changes that have occurred in the use of the term recovery in relation to mental health conditions; differences among key stakeholder groups in their attitudes and beliefs concerning recovery; and cross-cultural understandings of mental health recovery³.

Historically, the concept of recovery in the context of chronic mental health conditions has undergone significant change during the past century. One study reviewing admissions to a Cornwall asylum in the 1870's, found that patients were discharged with the status 'recovered' recorded in the hospital register, although it is unclear what criteria were used to make this determination⁴. While some patients may have fully recovered, many were subsequently readmitted to these institutions giving rise to the concept of the revolving door. Several authors have pointed out that full recovery in psychotic conditions is more common than many people think. A review of 114 international outcome studies conducted over the last century, found complete recovery from schizophrenia was reported in around 20 % of cases and social recovery in 35-46 % of cases⁵. The variance in outcomes attributable to effective treatment remains unknown^{3,5,6}. Furthermore, other research has pointed out that many people who hear voices lead relatively normal lives and never come to clinical attention⁷.

Following the de-institutionalization movement, an increasing need for psychosocial support in the community led to a focus on psychiatric rehabilitation and 'functional recovery'. The goal of functional recovery is to optimize functioning despite ongoing symptoms. The concept of 'functional recovery' recognizes that people diagnosed with the same condition, of similar severity, may demonstrate very different levels of functional capacity. Historically, it was believed that clinical recovery would automatically lead to recovery in other areas of life including employment, education, and community participation; however, research has shown that this is not necessarily the case⁸. Indeed, it has been argued that while treatment of mental health symptoms may facilitate personal recovery it can also hinder it, particularly if it is associated with coercive practices³. The World Health Organization International Classification of Functioning, Disability and Health (ICF) model proposes that functioning is not only an outcome of a medical condition, but also plays an important role in determining the course of the medical condition⁹. While this conceptualization has long been embraced for physical conditions, using a range of therapies to promote functionality, its relevance for people living with persisting and severe mental health conditions has been less well recognized. The ICF model highlights the dynamic and reciprocal relationship between participation, activities and a mental health condition, in which personal and environmental factors influence activity and participation, which in turn impact the status of the mental health condition.

During the last two decades, the meaning of recovery in severe and persisting mental health conditions has undergone further significant change^{10,11}. Anthony (1993) defined recovery from mental illness as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles - a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness” (p.5.), involving the development of new meaning and purpose in one’s life¹². Whitwell (2001) proposed the term ‘personal recovery’ be used to differentiate this prolonged process from medical outcomes¹³. Slade (2010) also has been made a distinction between personal recovery and clinical recovery¹⁴. Slade et al view recovery as a uniquely personal process which may not involve symptom reduction and is best evaluated by the individual concerned (3). This conceptualization is central to the Australian framework for recovery-oriented health services which defines personal recovery in terms of the ability to create and live a meaningful and contributing life in a community of choice irrespective of the presence of mental health issues¹⁵.

The term ‘social recovery’ was coined to describe people living with schizophrenia who, despite experiencing ongoing symptoms, had achieved a state of economic and residential independence with low social disruption¹⁶. This involved working adequately to provide for oneself and not being dependent on others for basic needs or housing. Some recovery theorists argue for the centrality of social factors such as social connectedness and social inclusion in recovery and best practice guidelines for recovery-oriented services often highlight the importance of citizenship and participation¹⁷. A systematic review of personal recovery studies, identified connectedness as an essential element in the recovery process¹⁸. Connectedness was conceived in terms of peer support and support groups, relationships, support from others, and being part of the community. Tools developed to measure recovery have also incorporated interpersonal factors as relevant to the recovery process¹⁹.

Researchers have reported that key stakeholder groups involved in the recovery process, including clinicians and clients, hold differing views of recovery. Among clinicians, there remains a significant lack of consensus around what is meant by the term recovery in the context of severe and persisting mental health conditions. A study of perceptions concerning the meaning of recovery in schizophrenia among medical students and trainee psychiatrists in Hong Kong found an overemphasis on symptomatic recovery and entrenched negative attitudes towards the possibility of recovery in schizophrenia²⁰. Another study found that understandings of recovery among mental health nurses and service users were vague and contradictory²¹. A third study found that people experiencing first episode psychosis conceived recovery in a broader sense than is usually accepted in medical circles²².

In relation to vocational recovery, significant discrepancies appear to exist between client and clinician beliefs.²³ Some beliefs are clearly not conducive to recovery outcomes³. For example, studies have found that participants who were employed considered themselves recovered despite experiencing ongoing symptoms and maintaining treatment^{24,25}. However, despite an increasing awareness that participation in meaningful employment may constitute an integral part of recovery^{3, 10, 26} clinicians’

expectations of recovery in psychotic conditions remain low and appear to lag behind empirical research findings²⁷. The persisting low expectations of clinicians may be due in part to the negative prognostications of respected psychiatric pioneers such as Kraepelin, and in part due to the clinician's illusion resulting from their selective exposure in treatment settings to more severe and relapsing cases²⁸.

In contrast, certain non-government sector organizations involved in supporting people living with severe and persisting mental health conditions are not only optimistic that recovery is possible but present training courses on the subject²⁹. Consumer groups insist that there is a need to be more attentive to the voice of consumers who are 'experts by experience'. Innovative new approaches to the management of symptoms have been developed by people with lived experience²⁹. Increasingly there is a focus on examining recovery from a client perspective. The mental health plan for England 2009-2019 "has the expectation that services treat and care for people with mental health problems based on the best available evidence and focused on recovery, as defined in discussion with the service user"¹⁸. Some studies have suggested that input from people with lived experience of psychosis in training programs for mental health professionals would promote recovery-oriented practice^{30, 31}. Increasingly research into recovery is focussing on analysis of narrative accounts of people with lived experience of mental illness³².

There also appear to be international differences in defining and measuring recovery. A comparison of policy and practice in Australia and the United Kingdom, concluded that recovery from mental illness was an emergent concept which was interpreted and implemented differently in these two settings¹. In a meta-analysis of studies addressing recovery across 11 English-speaking countries it was found that in the USA and UK the focus of recovery tends to be on connectedness; in Canada and the UK, relatively higher importance was placed on meaningfulness of life; while in Australia there was a marked focus on strengths³³. It has been suggested, however, that the current international focus of policy on recovery is in advance of scientific evidence as well as clinical practice¹⁴.

In the absence of a widely accepted definition of recovery and measurable recovery outcomes in the context of people living with psychosis, recovery remains an elusive construct. There are significant challenges in measuring recovery, with ongoing debate regarding the most suitable assessment procedure³⁴. These factors may contribute to a lack of accountability for the achievement of functional outcomes including social and vocational re-integration into mainstream society. This study aimed to explore the concept of recovery in psychosis from the perspectives of multiple stakeholder groups using data from a large qualitative study conducted in South East Queensland, Australia.

Research Design and Method

A qualitative design was used in this study as qualitative methods have proven useful to gain new insights and extend understanding of relevant variables³⁵. The study used

qualitative methods consistent with thematic analysis³⁶. Approval for this study was obtained from the researchers' university ethics committee. A purposive sample of 137 participants was invited to participate in focus groups and individual interviews designed to elicit perceptions of the employment barriers and support needs of people living with psychosis. Data obtained from this large qualitative study was used to explore participant perceptions of the concept of recovery in the context of psychotic conditions. Table 1 shows the composition of the sample³⁷.

Table 1. Composition of Sample: Focus Groups and Interviews

Stakeholder group	No. of focus groups	No. of group participants	No. of individual interviewees	Total participants
Clients	3	17	8	25 (18%)
Carers	1	7	2	9 (6%)
Employers	1	8	3	11 (8%)
Employment consultants	3	24	3	27 (20%)
Community members	5	41	5	46 (34%)
Health professionals	1	9	10	19 (14%)
Total	14	106	31	137 (100%)

Note. One community member group was composed exclusively of young people aged 18-25 years while another consisted of representatives of community service organizations.

Participants from six key stakeholder groups were engaged in the study: clients (n=25), carers (n=9), employers (n=11), health professionals (n=19), employment consultants (n=27), and community members (n=46). It was considered that eliciting the views of multiple key stakeholder groups would yield a comprehensive understanding of the topic under investigation. Participants were recruited by contacting individuals, service providers and community organisations in the catchment area of South East Queensland. All participants provided informed consent. Ethical approval for this study was obtained from Bond University. Participants who were acutely unwell at the time of the study were to be excluded. Only one participant was excluded by the researcher following a third party report that the person was acutely unwell at the time of the study.

Biographical information was obtained from all participants. The sample included participants aged across the adult life-span (18-84 years), reflecting a wide range of educational attainment and occupational categories. Data collection proceeded in two phases: focus groups (n=14) followed by individual interviews (n=31). Focus groups were chosen as a research method as they can reduce the balance of power between the researcher and participants and enable the voice of marginalized groups to be heard³⁸. Focus groups consisted of three to ten participants from the same stakeholder group to maximize freedom of expression. Recruitment to focus groups was purposive, based on stakeholder affiliation. Following completion of the focus groups, individual interviews were conducted. Interviewees were recruited by the researchers with a view to include individuals whose employment experiences diverged from the norm, for example, people living with psychosis and reporting positive employment experiences, and employers with past experience employing people living with psychosis. The purpose of the individual interviews was to expand the range of participants included in the study; capture new ideas, address gaps in understanding; and test novel ideas raised in focus groups. Focus groups and interviews were conducted by the first author, a registered clinical psychologist, who provided ground rules to ensure participant well-being as well as minimal encouragers and prompts to keep the discussion on track. A second registered psychologist was present in a supportive role during client focus groups to ensure client safety. Questions were posed during focus groups and interviews to elicit participants' perceptions of employment barriers and support needs of people living with psychosis. During the course of these discussions views on recovery emerged which are the focus of the current paper.

Interview schedules consisted of semi-structured questions, tailored to elicit the perceptions of particular stakeholder groups. Examples of interview items can be found by reference to Hampson's unpublished thesis³⁷. A responsive interviewing style was used during interviews³⁵. Focus groups and interviews were conducted until a point of saturation was reached when no new themes emerged³⁹. Thematic analysis was used in the analysis phase of the study³⁶. The findings in relation to the employment barriers and support needs of people living with psychosis are presented in a separate paper⁴⁰. The current paper focuses on participants' perceptions of recovery in relation to people living with psychosis.

Transcripts were thoroughly searched for references to the word *recovery*. The word search function in NVivo was used to ensure that all references to recovery were identified, using search terms including 'recover', 'recovery' and 'recovered'. References to recovery were carefully examined and were initially coded to free nodes or themes. Recovery references were analyzed thematically and progressively subsumed under higher order nodes/themes through an inductive process. Further details concerning the sample composition and study method can be obtained in the unpublished thesis by Hampson³⁷. In the following section, we present the findings for participant perceptions of the concept of recovery in the context of psychotic conditions.

Results

Conceptualizations of Recovery

Recovery was seen to be imbued with personal philosophies and social and political connotations. Health professionals suggested that the concept of recovery in the context of mental health is an abstract concept with undefined goals, which is difficult to grasp intellectually and to measure. A medical officer observed:

"I do have some difficulties with the whole concept of recovery. It's quite a broad [concept]...and we're not really geared up to measure whether somebody's recovered or not so I find that's difficult...to just intellectually come to grips with. I mean how do I know if somebody's recovered? Well they don't have symptoms but they're back at work or, you know, how do you measure those things? It's not spelled out clearly for us to measure."

Some health professionals perceived the use of the word recovery to have political connotations. A psychiatrist said, "The idea of recovery, is all well and good and I think it's a bit of a political elephant now really".

Participants' understanding of the meaning of recovery is reflected in five different usages of the word *recovery*: symptomatic relief; a contented life; a meaningful life; a contributing life; and functional recovery. These constructions draw on clinical, personal and social components of recovery, and employ both objective and subjective criteria. In the sections that follow each of the five themes is described with relevant participant references provided. The sources of references have been included to provide context and enhance the meaningfulness of the data.

1. Symptomatic Relief

Participants used the word 'recovery', in the same sense that it is commonly used in relation to physical conditions: the sense of relief or remission of clinical symptoms, or a period of recuperation following an acute episode or hospitalisation. For example, a psychiatrist said, "...the person's recovered and there's no voices or the mania; they become euthymic".

Client participants also used the word recovery in this medical sense:

"I think most of them (people diagnosed with psychosis) should be employed soon after they've been considered to have recovered enough, and... I don't think that should be so very late after they come out [of hospital]. I think they should have some work to go to."

A client participant also alluded to the medical concept of cure:

"I have had a mental illness and I think I'm completely cured a couple of years ago, I take no tablets and all that sort of thing."

2. *A Contented Life*

Recovery was also conceptualized in terms of more personal and subjective outcomes such as the attainment of a contented life. A medical officer philosophised that personal happiness and contentment with life/lifestyle were more important than other recovery outcomes:

"I challenge some of my staff like that sometimes. You know they tell me, "Ah so and so he's not doing this and he's not doing that and bla, bla and I'm going, "Are they happy?...It's also about people's happiness, you know."

A client described his sense of satisfaction with his lifestyle in this way:

"...I'm going to continue with the disability support pension 'cause I'm doing quite nicely. Once you get to the normal pension, plus you get the things like the rental allowances and all that, I'm doing alright. I mean I go to Melbourne, I get expensive shirts, expensive shorts, expensive pants, I've seen the Melbourne Cup. I saw the tennis at Melbourne this year, it was in January. So, I get my groceries and all that and my sister looks after my money...and she said something a few months ago ah you've got fifteen hundred dollars in the bank, you can get some new shirts, you know, so I said righto go ahead and buy them for me. So, if something [employment] comes along, where I can sit on my bum, I'll take it."

3. *Meaningful Life*

This theme captured references to recovery conceptualized in terms of an individual's achievement of meaning and purpose in his/her life. A psychologist commented:

"It's about the individual and what they want. What they see as potentially meaningful and purposeful activity for their life. It might not be employment...ask people what they want to do with their lives despite their mental health conditions and then go from there."

Another psychologist echoed this view:

"There are some people for whom going back to work is not realistic and for them recovery is more around them being able to live a fulfilling life in other ways...there will always be some who realistically can't but that doesn't mean that they can't be meaningfully occupied."

Some clinicians cautioned against clinicians or society determining recovery outcomes and suggested it is a uniquely personal journey. A mental health nurse stated:

"We're pushing our opinions onto people (sighs)...We, as in the mental health service, could be saying and society is saying, well to be well you need to be employed and this is what we're all doing so you should do it too...but hang on a minute, I've got schizophrenia and it's inhibiting me a hell of a lot. I can't even go into the bank without feeling paranoid. So, I do think that we do impose our own opinions onto people and expectations, and I feel and I've certainly seen it in developmentally disabled people that the expectations of society are much higher than what these people are quite capable of achieving...and you'll find that they'll relapse into or act out in defence because they can't communicate particularly well and it'll be an emotional response or whatever and it'll come out as symptomatology of their illness or their disability."

4. A Contributing Life

This theme included responses that envisioned recovery as a positive state of "flourishing", which extended beyond medical management to gaining a sense of hope and leading a valued, fulfilling and contributing life. A caregiver remarked:

"Recovery used to mean, for a lot of health professionals, that their medication was there...not that they were a flourishing...they'd often be languishing at home...or just not moving forward or having something to look [forward to]. To flourish you've got to have something to look forward to...You need some hope. You need also something that you can do and really for people to flourish they usually need to feel they're contributing in some way in society in general."

Participants suggested the need for more flexibility in conceptualizing a contributing life. It was suggested that a contributing life may involve employment or contributing to the community in another way such as caring for family or neighbours or volunteering. A carer said, "It doesn't have to be a great big way it could be a little thing. It might be that it's doing some gardening for the old person down the street or it could be all sorts of things."

Similarly, a health professional pointed out that there will always be people who cannot enter the workforce yet contribute to society in other ways:

"It just may not be in what we traditionally think of as a paid work role...they can still contribute. There are various contributions they can make. An obvious one is that they can be available as a companion or a friend of someone else with a mental illness like a buddy, support person. It really depends on the individual. They can be more active in

their family. It really depends on what the person themselves considers to be a fulfilling life. There would be many people who are contributing and are able to contribute to their community, to society, to their families...and enrich their own lives that actually don't involve paid payment..."

5. *Functional Recovery*

This theme included references to the view that some people diagnosed with a psychotic condition are able to function in activities of daily living despite ongoing symptoms. A psychologist commented:

"I don't think people need to be symptom-free [before they can work]. I think that we need to expose more in the public forum that a lot of people work all the time with a varying range of medical conditions and they manage them. That it's not an uncommon thing at all for people to be working and managing conditions. That it's a very normal thing...whether it be a mental condition or physical condition or genetic condition...and if people are waiting to be clear and free of symptoms they'll only go to work and find that Jo Bloggs is coming to work with a cold and sniffing everywhere and miserable (laughs) or so and so's been out too late night before and they're tired...and you don't have to be perfect to be working."

A peer support worker described recovery as "returning to your life". Despite ongoing symptoms some people may function relatively well in certain areas of their life. A medical officer related:

"I used to have a patient who ran their own shop in XXX, did so for years, and you wouldn't know...she had voices most of the day, yeah, worse at night when she got home because she wasn't distracted any more. Yeah, so that was useful...we've got people running their own businesses from Clozapine. Clozapine's a good drug for that. I noticed when I stopped doing it and then I came back and filled in for someone eighteen months later sort of thing I'd be seeing people who I'd be going "Wow, look at you. Who'd have thought you'd get back to work?"...and they are...or, if they're not back at work, they're out there interacting more..."

A psychologist described his understanding of the word 'recovery' in the context of schizophrenia or bipolar disorder saying "...my understanding of recovery is self-awareness and getting back to some sort of positive functioning state...the idea is that they get back and live their lives quite normally if they can."

Recovery was also described in terms of participation in activities of everyday life. A mental health nurse remarked: "So you can take it back to its simplest form and well just to get out of the house and walk down to the beach is a major accomplishment for some people". A psychiatrist perceived recovery in terms of participation in conventional social

roles:

"My concept of recovery is where a person really is 'functioning like you and I'. In other words, they've got a job which suits them, and they're happy with the job; they've got relationships; they've got hobbies; they've got sport."

Discussion

This study extends the findings of previous studies by inclusion of multiple stakeholder groups, providing the opportunity to capture a diverse array of perspectives on recovery, including clinical and non-clinical perspectives. The findings demonstrate five different conceptualizations that exist in relation to recovery in psychosis: symptomatic relief; a contented life; a meaningful life; a contributing life; and functional recovery. The findings strongly support the proposal of Lam et al. that conceptualization of recovery needs to extend beyond a narrow medical conceptualization in terms of clinical recovery²². It also highlights that recovery should extend beyond personal recovery to include social and vocational recovery. The findings of this study demonstrate that recovery in the context of severe and persisting mental health conditions such as psychotic disorders remains a complex and elusive construct. The study identified multiple perspectives on how recovery may be conceptualized. Although conceptualized by some participants in a narrow sense of symptomatic improvement, the concept of recovery was also conceived by many to extend well beyond the realm of symptoms. This broader conceptualization is consistent with Davidson's view that recovery represents a level of personal integration and transcendence that extends beyond mere cure of problematic symptoms⁶. What was evident from the responses of participants is that, consistent with previous literature, the recovery concept includes not only objective aspects such as symptomatic and functional improvement but also subjective aspects such as leading a personally meaningful and contributing life³⁴.

Each of the five thematic concepts of recovery advanced by participants may be problematic when considered on its own. A problem with the 'symptomatic recovery' view is that despite optimal treatment, mental illness typically follows a fluctuating course. Another problem with this view is that the link between severity of symptoms and everyday functioning remains tenuous⁸. Many people living with psychosis may experience symptomatic improvement without corresponding functional improvement, while others may have ongoing symptoms throughout their life but nevertheless function positively in important aspects of their life such as work and social roles. 'Functional recovery' on the other hand may well occur in the presence of ongoing symptoms which the person may find very disruptive and distressing. 'Personal contentment' may potentially include unhealthy or dysfunctional habits or behaviours such as substance abuse which may lead to exacerbation of symptoms and functional deterioration. The 'meaningful' life, 'contributing' life and 'flourishing' concepts of recovery are also problematic in that many individuals who are unaffected by mental health problems may not be leading lives that others would consider meaningful, contributing or flourishing.

Indeed, there is no universally accepted benchmark for what constitutes a meaningful, contributing or flourishing life.

Given the diverse array of conceptualizations of recovery, any attempt to define recovery is fraught with difficulty. The England mental health plan suggests that recovery be defined in discussion with service providers¹⁸; however, this is likely to render it less personal and subject to known negative clinician bias²⁷. Based on the responses of participants in this study, recovery might be defined as a return to adaptive functioning and re-integration into personally valued social roles despite the presence or absence of ongoing symptoms. Such improvement in functionality, through participation in activities, may in turn contribute to symptomatic improvement¹⁷. Importantly, the diverse conceptualisations found in this study suggest the range of measurable recovery outcomes should be broadened. To capture all five aspects of recovery conceived by participants, we suggest that in addition to objective measures of symptomatic improvement and adaptive functioning, a battery of subjective measures is needed. Such measures might include a quality of life inventory, contentment with life scale⁴¹ and/or a subjective vitality scale⁴².

Despite the obvious difficulties in terms of definition and measurement, the word recovery has become common parlance in mental health circles and services are funded to support recovery of people living with psychosis. Significantly, the current study suggests health professionals may embrace the recovery concept less enthusiastically than other stakeholders. This is consistent with previous research findings that clinicians tend to have low expectations and hold stigmatising attitudes towards their clients^{27, 43}. The tendency of health professionals to view recovery as a uniquely personal journey with individualised goals also lends itself to downward adjustments by health professionals, particularly those working in institutional settings, who often perceive patient goals as unrealistic²³. Consequently, there is a risk that clinicians may be inclined to negotiate lower goals with their clients. A downside of the conceptualisation of recovery as a uniquely personal journey is that it prevents any form of comparative measurement and therefore potentially removes accountability for the achievement of more objective measures of social integration and citizenship. The view of the authors of this paper is that recovery should not be regarded as so personalised a journey that it can't be measured and clinicians held accountable for outcomes.

A limitation of this study is that the sample was purposive rather than random and participants were on average somewhat older and more educated than the general population. Nevertheless, the in-depth nature of the enquiry and the inclusion of multiple stakeholder groups yielded rich data which can be tested in future empirical studies. A second limitation pertains to the focus of the current study on employment barriers and support needs, which may have restricted participants' thinking about the concept of recovery. Future qualitative studies investigating recovery could pose broader research questions beyond the employment domain.

Conclusion

More research is needed to explore clinician and public understanding and expectations around the concept of recovery. Future studies might examine whether there are differences in conceptualizing recovery depending on the participants' background including stakeholder group affiliation, for example client versus caregiver or clinician. There is a need to refocus attention on how recovery is defined and on the variables instrumental in achieving this outcome among those who have recovered. Further research is also needed to improve standardized outcome measures of recovery in psychosis in order to adequately capture all aspects of this multidimensional construct. Finally, recovery implies restoration of a previous state of health or wellbeing. In the context of mental health, more attention has focussed on understanding mental ill health or psychopathology than on understanding mental well-being and how it can be conceived and measured. In seeking to understand recovery there is a need for continued research into the conceptualization, definition and measurement of 'mental well-being' as the ultimate goal of recovery.

The challenge of conceptualizing and measuring recovery in people living with psychosis remains an ongoing and important challenge in the field. The different understandings of recovery elicited in this study point to a need for more education, communication and collaboration to ensure shared understanding of recovery among key stakeholder groups if the goals of recovery-oriented services are to be realized. Until there is consensus on what is meant by 'recovery' in the context of chronic mental health conditions and a standardized measure of recovery is established, the goals and efficacy of recovery-oriented services will remain poorly defined and treatments will continue to be provided without adequate accountability for the outcomes achieved.

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